SENATE BILL No. 603

DIGEST OF INTRODUCED BILL

Citations Affected: IC 4-22-2-37.1; IC 4-23; IC 12-7-2; IC 12-8-1-14; IC 12-13-8-4; IC 12-15; IC 12-17-18; IC 12-17.6; IC 35-43-5-7.2.

Synopsis: Children's health insurance program. Establishes the children's health insurance program within the office of the secretary of family and social services to provide health insurance coverage to uninsured children. Establishes the children's health policy board to oversee implementation of the program and to coordinate aspects of existing children's health programs. Provides that an individual who is less than 19 years old and who is a member of a family with an annual income that is less than 150% of the federal income poverty level is eligible for Medicaid. Requires the children's health insurance program to use the same infrastructure as the Medicaid managed care program for children to the greatest extent possible. Provides eligibility requirements that a child and the child's family must meet in order to enroll in the program. Provides that providers enrolled under the Medicaid program and providers enrolled under the children's health insurance program are considered to be providers for both programs. Makes conforming changes.

Effective: Upon passage; July 1, 1999.

C o p y

Simpson, Miller, Johnson

January 21, 1999, read first time and referred to Committee on Rules and Legislative Procedure.

Introduced

First Regular Session 111th General Assembly (1999)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 1998 General Assembly.

Copy

SENATE BILL No. 603

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 4-22-2-37.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 37.1. (a) This section applies to a rulemaking action resulting in any of the following rules:

(1) An order adopted by the commissioner of the Indiana department of transportation under IC 9-20-1-3(d) or IC 9-21-4-7(a) and designated by the commissioner as an emergency rule.

(2) An action taken by the director of the department of natural resources under IC 14-22-2-6(d) or IC 14-22-6-13.

(3) An emergency temporary standard adopted by the occupational safety standards commission under IC 22-8-1.1-16.1.

(4) An emergency rule adopted by the solid waste management board under IC 13-22-2-3 and classifying a waste as hazardous.

(5) A rule, other than a rule described in subdivision (6), adopted by the department of financial institutions under IC 24-4.5-6-107 and declared necessary to meet an emergency.

(6) A rule required under IC 24-4.5-1-106 that is adopted by the department of financial institutions and declared necessary to meet an emergency under IC 24-4.5-6-107.

(7) A rule adopted by the Indiana utility regulatory commission to address an emergency under IC 8-1-2-113.

(8) An emergency rule jointly adopted by the water pollution control board and the budget agency under IC 13-18-13-18.

(9) An emergency rule adopted by the state lottery commission under IC 4-30-3-9.

(10) A rule adopted under IC 16-19-3-5 that the executive board of the state department of health declares is necessary to meet an emergency.

(11) An emergency rule adopted by the Indiana transportation finance authority under IC 8-21-12.

(12) An emergency rule adopted by the insurance commissioner under IC 27-1-23-7.

(13) An emergency rule adopted by the Indiana horse racing commission under IC 4-31-3-9.

(14) An emergency rule adopted by the air pollution control board, the solid waste management board, or the water pollution control board under IC 13-15-4-10(4) or to comply with a deadline required by federal law, provided:

(A) the variance procedures are included in the rules; and

(B) permits or licenses granted during the period the emergency rule is in effect are reviewed after the emergency rule expires.

(15) An emergency rule adopted by the Indiana election commission under IC 3-6-4.1-14.

(16) An emergency rule adopted by the department of natural resources under IC 14-10-2-5.

(17) An emergency rule adopted by the Indiana gaming commission under IC 4-33-4-2, IC 4-33-4-3, or IC 4-33-4-14.

(18) An emergency rule adopted by the alcoholic beverage commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or IC 7.1-3-20-24.4.

(19) An emergency rule adopted by the department of financial institutions under IC 28-15-11.

(20) An emergency rule adopted by the office of the secretary of family and social services under IC 12-8-1-12.

Copy

(21) An emergency rule adopted by the office of the children's health insurance program under IC 12-17.6-2-6.

(b) The following do not apply to rules described in subsection (a):

(1) Sections 24 through 36 of this chapter.

(2) IC 13-14-9.

(c) After a rule described in subsection (a) has been adopted by the agency, the agency shall submit the rule to the publisher for the assignment of a document control number. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The publisher shall determine the number of copies of the rule and other documents to be submitted under this subsection.

(d) After the document control number has been assigned, the agency shall submit the rule to the secretary of state for filing. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The secretary of state shall determine the number of copies of the rule and other documents to be submitted under this subsection.

(e) Subject to section 39 of this chapter, the secretary of state shall:

(1) accept the rule for filing; and

(2) file stamp and indicate the date and time that the rule is accepted on every duplicate original copy submitted.

(f) A rule described in subsection (a) takes effect on the latest of the following dates:

(1) The effective date of the statute delegating authority to the agency to adopt the rule.

(2) The date and time that the rule is accepted for filing under subsection (e).

(3) The effective date stated by the adopting agency in the rule.

(4) The date of compliance with every requirement established by law as a prerequisite to the adoption or effectiveness of the rule.

(g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6, and IC 22-8-1.1-16.1, a rule adopted under this section expires not later than ninety (90) days after the rule is accepted for filing under subsection (e). Except for a rule adopted under subsection (a)(14), the rule may be extended by adopting another rule under this section, but only for one (1) extension period. A rule adopted under subsection (a)(14) may be extended for two (2) extension periods. Except for a rule adopted under subsection (a)(14), for a rule adopted under this section to be effective after one (1) extension period, the rule must be adopted under:

(1) sections 24 through 36 of this chapter; or

C o p y

(2) IC 13-14-9;

as applicable.

(h) A rule described in subsection (a)(6), (a)(9), or (a)(13) expires on the earlier of the following dates:

(1) The expiration date stated by the adopting agency in the rule.

(2) The date that the rule is amended or repealed by a later rule adopted under sections 24 through 36 of this chapter or this section.

(i) This section may not be used to readopt a rule under IC 4-22-2.5.

SECTION 2. IC 4-23-26 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 26. Advisory Committee for Children With Special Health Needs

Sec. 1. As used in this chapter, "committee" refers to the advisory committee for children with special health needs established by section 2 of this chapter.

Sec. 2. The advisory committee for children with special health needs is established.

Sec. 3. The committee consists of the following members:

(1) The director of the children's special health care services program.

(2) The director of the first steps early intervention system.

(3) The chair of the governor's interagency coordinating council for early intervention.

(4) The chair of the children's special health care needs advisory council under 410 IAC 3.2-11.

(5) The chair of the state advisory council on the education of children and youth with disabilities under 511 IAC 7-5-1.

(6) One (1) representative of the Indiana chapter of the American Academy of Pediatrics.

(7) One (1) representative of a family advocacy group.

(8) Three (3) parents of children with special health needs.

Sec. 4. (a) The governor shall appoint the committee members under section 3(6), 3(7), and 3(8) of this chapter.

(b) The term of each member appointed under subsection (a) is three (3) years.

(c) A committee member identified in subsection (a) may be reappointed to serve consecutive terms.

Sec. 5. (a) The director of the children's special health care services program is chair of the committee during odd-numbered years.

Copy

(b) The director of the first steps program is chair of the committee during even-numbered years.

Sec. 6. The committee shall meet at least quarterly at the call of the chair.

Sec. 7. (a) Six (6) members of the committee constitute a quorum.

(b) The affirmative vote of at least six (6) members of the committee is required for the committee to take any official action.

Sec. 8. (a) Each member of the committee who is not a state employee is entitled to receive both of the following:

(1) The minimum salary per diem provided by IC 4-10-11-2.1(b).

(2) Reimbursement for travel expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency.

(b) Each member of the committee who is a state employee is entitled to reimbursement for travel expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency.

Sec. 9. The committee shall advise and assist the children's health policy board established by IC 4-23-27-2 in the development, coordination, and evaluation of policies that have an impact on children with special health needs by doing the following:

(1) Seeking information from families, service providers, advocacy groups, and health care specialists about state or local policies that impede the provision of quality service.

(2) Taking steps to ensure that relevant health policy issues that have an impact on children with special health needs are forwarded to the children's health policy board.

(3) Advising the children's health policy board with respect to the integration of services across:

(A) programs; and

(B) state agencies;

for children with special health needs.

SECTION 3. IC 4-23-27 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Copy

Chapter 27. Children's Health Policy Board

Sec. 1. As used in this chapter, "board" refers to the children's health policy board established by section 2 of this chapter.

Sec. 2. The children's health policy board is established to do the following:

(1) Coordinate programs designed to provide health care to children and their families, including the Medicaid managed care program for children, children with special health care needs, first steps, and the children's health insurance program, in order to achieve a more seamless system that is easy to access for both participants and providers, specifically in the following areas:

(A) Identification of potential enrollees.

(B) Outreach.

(C) Eligibility criteria.

(D) Enrollment.

(E) Benefits and coverage issues.

(F) Provider requirements.

(G) Evaluation.

(H) Procurement policies.

(I) Information technology systems.

(2) Oversee implementation of the children's health insurance program.

(3) Develop a comprehensive policy in the following areas:

(A) Appropriate delivery systems of care.

(B) Enhanced access to care.

(C) The maximum use of funding for various programs.

(D) The maximum provider participation in various programs.

(E) The potential for expanding health insurance coverage to other populations.

(F) Future technology needs.

(G) Appropriate organizational structure to develop health policy in the state.

(4) Collect, analyze, disseminate, and use data when making policy decisions.

Sec. 3. The board consists of the following members:

(1) One (1) member from the division of family and children, appointed by the secretary of the office of family and social services.

(2) One (1) member from the office of Medicaid policy and planning, appointed by the secretary of the office of family

Copy

and social services.

(3) Two (2) members from the state department of health, appointed by the commissioner of the department of health.

(4) Two (2) members from the department of insurance, appointed by the commissioner of the department of insurance.

(5) Two (2) members of the senate, appointed by the president pro tempore of the senate with the advice of the minority leader of the senate. The members appointed under this subdivision may not belong to the same political party.

(6) Two (2) members of the house of representatives, appointed by the speaker of the house of representatives with the advice of the minority leader of the house of representatives. The members appointed under this subdivision may not belong to the same political party.

(7) Two (2) members appointed by the governor, including at least one (1) individual from a family who receives services from the children's health insurance program.

Sec. 4. (a) Seven (7) members of the board constitute a quorum.

(b) The affirmative vote of seven (7) members of the board is required for the board to take any official action.

Sec. 5. The governor shall annually appoint a chair from among the members of the board.

Sec. 6. (a) The board shall meet monthly at the call of the chair.

(b) In addition to the meetings held under subsection (a), the board shall hold public hearings as determined by the chair.

Sec. 7. (a) Except as provided in subsections (b) and (c), the term of each member of the board is three (3) years.

(b) If a legislative member of the board ceases being a member of the chamber from which the member was appointed, the member also ceases to be a member of the board.

(c) If a member of the board described in section 3(1), 3(2), 3(3), or 3(4) of this chapter ceases being an employee of the division of family and children, the office of Medicaid policy and planning, the state department of health, or the department of insurance, respectively, the member also ceases to be a member of the board.

(d) A member may be reappointed to serve consecutive terms.

Sec. 8. If a vacancy exists on the board, the appointing authority who appointed the former member whose position has become vacant shall appoint an individual to fill the vacancy.

Sec. 9. (a) Each member of the board who is not a state employee is entitled to receive both of the following:

C o p y

(1) The minimum salary per diem provided by IC 4-10-11-2.1(b).

(2) Reimbursement for travel expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency.

(b) Each member of the board who is a state employee is entitled to reimbursement for travel expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency.

(c) The legislative members of the board are entitled to receive the same per diem, mileage, and travel allowances paid to persons who serve as legislative members of interim study committees established by the legislative council.

Sec. 10. (a) The board shall establish objectives for evaluating the children's health insurance program based on health care benchmarks.

(b) The board shall contract with an independent organization to evaluate the children's health insurance program.

(c) An evaluation under subsection (b) must occur one (1) time every two (2) years.

(d) This section does not modify the requirements of other statutes relating to the confidentiality of medical records.

Sec. 11. Based on each evaluation conducted under section 10 of this chapter, the board shall make recommendations to the general assembly for changes in the children's health insurance program.

Sec. 12. The board may draw upon the expertise of other boards, committees, and individuals whenever the board determines that such expertise is needed.

SECTION 4. IC 12-7-2-52.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 52.2. "Crowd out", for purposes of IC 12-17.6, has the meaning set forth in IC 12-17.6-1-2.**

SECTION 5. IC 12-7-2-91 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 91. "Fund" means the following:

(1) For purposes of IC 12-12-1-9, the fund described in IC 12-12-1-9.

(2) For purposes of IC 12-13-8, the meaning set forth in IC 12-13-8-1.

Copy

(3) For purposes of IC 12-15-20, the meaning set forth in IC 12-15-20-1.

(4) For purposes of IC 12-17-12, the meaning set forth in IC 12-17-12-4.

(5) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-3.

~~(5)~~ **(6)** For purposes of IC 12-18-4, the meaning set forth in IC 12-18-4-1.

~~(6)~~ **(7)** For purposes of IC 12-18-5, the meaning set forth in IC 12-18-5-1.

~~(7)~~ **(8)** For purposes of IC 12-19-3, the meaning set forth in IC 12-19-3-1.

~~(8)~~ **(9)** For purposes of IC 12-19-4, the meaning set forth in IC 12-19-4-1.

~~(9)~~ **(10)** For purposes of IC 12-19-7, the meaning set forth in IC 12-19-7-2.

~~(10)~~ **(11)** For purposes of IC 12-23-2, the meaning set forth in IC 12-23-2-1.

~~(11)~~ **(12)** For purposes of IC 12-24-6, the meaning set forth in IC 12-24-6-1.

~~(12)~~ **(13)** For purposes of IC 12-24-14, the meaning set forth in IC 12-24-14-1.

~~(13)~~ **(14)** For purposes of IC 12-30-7, the meaning set forth in IC 12-30-7-3.

SECTION 6. IC 12-7-2-120 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 120. (a) "Insurer", for purposes of the statutes listed in subsection (b), means an insurance company, a health maintenance organization (as defined in IC 27-13-1-19), a self-funded employee benefit plan, a pension fund, a retirement system, or a similar entity that:

(1) does business in Indiana; and

(2) is under an obligation to make payments for medical services as a result of injury, illness, or disease suffered by an individual.

(b) ~~This section~~ **Subsection (a)** applies to the following statutes:

(1) IC 12-14-1 through IC 12-14-9.

(2) IC 12-15, except IC 12-15-32, IC 12-15-33, and IC 12-15-34.

(c) "Insurer", for purposes of IC 12-17.6, has the meaning set forth in IC 12-17.6-1-4.

SECTION 7. IC 12-7-2-134 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 134. "Office" means the following:

(1) Except as provided in subdivisions (2) and (3), the office of

Copy

Medicaid policy and planning established by IC 12-8-6-1.

(2) For purposes of IC 12-10-13, the meaning set forth in IC 12-10-13-4.

(3) For purposes of IC ~~12-17-18,~~ **IC 12-17.6,** the meaning set forth in ~~IC 12-17-18-1.~~ **IC 12-17.6-1-5.**

SECTION 8. IC 12-7-2-139.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 139.1. "Physicians' services", for purposes of ~~IC 12-17-18-18,~~ **IC 12-17.6,** has the meaning set forth in ~~IC 12-17-18-18(a).~~ **IC 12-17.6-1-6.**

SECTION 9. IC 12-7-2-146 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 146. "Program" refers to the following:

(1) For purposes of IC 12-10-7, the adult guardianship services program established by IC 12-10-7-5.

(2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5.

(3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-7.

SECTION 10. IC 12-7-2-149 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 149. "Provider" means the following:

(1) For purposes of IC 12-10-7, the meaning set forth in IC 12-10-7-3.

(2) For purposes of the following statutes, an individual, a partnership, a corporation, or a governmental entity that is enrolled in the Medicaid program under rules adopted under IC 4-22-2 by the office of Medicaid policy and planning:

(A) IC 12-14-1 through IC 12-14-9.

(B) IC 12-15, except IC 12-15-32, IC 12-15-33, and IC 12-15-34.

(C) IC 12-17-10.

(D) IC 12-17-11.

(3) For purposes of IC 12-17-9, the meaning set forth in IC 12-17-9-2.

(4) ~~For purposes of IC 12-17-18, the meaning set forth in IC 12-17-18-2.~~

~~(5)~~ For the purposes of IC 12-17.2, a person who operates a child care center or child care home under IC 12-17.2.

~~(6)~~ **(5)** For purposes of IC 12-17.4, a person who operates a child caring institution, foster family home, group home, or child placing agency under IC 12-17.4.

(6) For purposes of IC 12-17.6, the meaning set forth in

Copy

IC 12-17.6-1-8.

SECTION 11. IC 12-8-1-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 14. The office of the secretary shall improve its system through the use of technology and training of staff to do the following:**

(1) Simplify, streamline, and destigmatize the eligibility and enrollment processes in all health programs serving children.

(2) Ensure an efficient provider payment system.

(3) Improve service to families.

(4) Improve data quality for program assessment and evaluation.

(5) Coordinate payment for and services provided through the children's health insurance program under IC 12-17.6 with:

(A) services provided to children with special health needs; and

(B) public health programs designed to protect all children.

SECTION 12. IC 12-13-8-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. For taxes first due and payable in 1990, each county shall impose a medical assistance property tax levy equal to the amount determined using the following formula:

STEP ONE: Determine the sum of the amounts that were incurred by the county as determined by the state board of accounts for all medical care, including psychiatric care and institutional psychiatric care, for wards of the county office (described in ~~IC 12-15-2-15)~~ **IC 12-15-2-16)** that was provided in 1986, 1987, and 1988.

STEP TWO: Subtract from the amount determined in STEP ONE the sum of:

(A) the amount of bank taxes (IC 6-5-10);

(B) the amount of savings and loan association taxes (IC 6-5-11);

(C) the amount of production credit association taxes (IC 6-5-12); plus

(D) the amount of motor vehicle excise taxes (IC 6-6-5);

that were allocated to the county welfare fund and used to pay for the medical care for wards provided in 1986, 1987, and 1988.

STEP THREE: Divide the amount determined in STEP TWO by three (3).

STEP FOUR: Adjust the amount determined in STEP THREE by the amount determined by the state board of tax commissioners

Copy

under section 6 of this chapter.

STEP FIVE: Multiply the amount determined in STEP FOUR by the greater of:

(A) the assessed value growth quotient determined under IC 6-1.1-18.5-2 for the county for property taxes first due and payable in 1990; or

(B) the statewide average assessed value growth quotient using the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for property taxes first due and payable in 1990.

STEP SIX: Multiply the amount determined in STEP FIVE by the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this section will be first due and payable.

SECTION 13. IC 12-15-2-14 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 14. (a) An individual:

(1) who is less than ~~one (1) year~~ **nineteen (19) years** of age;

(2) who is not described in 42 U.S.C. 1396a(a)(10)(A)(i); and

(3) whose family income does not exceed the income level established in subsection (b);

is eligible to receive Medicaid.

(b) An individual described in this section is eligible to receive Medicaid, subject to 42 U.S.C. 1396a et seq., if the individual's family income does not exceed one hundred fifty percent (150%) of the federal income poverty level for the same size family.

(c) The office may apply a resource standard in determining the eligibility of an individual described in this section.

SECTION 14. IC 12-15-2-15.7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 15.7. ~~(a)~~ An individual who is less than nineteen (19) years of age and who is eligible for Medicaid under ~~sections~~ **section** 14 ~~through 15.6~~ of this chapter is eligible to receive Medicaid until the earlier of the following:

(1) The end of a period of twelve (12) consecutive months following a determination of the individual's eligibility for Medicaid.

(2) The individual becomes nineteen (19) years of age.

~~(b) This section expires August 31, 1999.~~

SECTION 15. IC 12-15-2.2-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. A qualified entity may establish the presumptive eligibility of an individual who may be eligible for:

Copy

(1) Medicaid under IC 12-15-2-11 through ~~IC 12-15-2-15.6;~~ **IC 12-15-2-14;** or

(2) services from the children's health insurance program under ~~IC 16-35-6.~~ **IC 12-17.6.**

SECTION 16. IC 12-15-2.2-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. The office shall provide each qualified entity with the following:

(1) Application forms for:

(A) Medicaid; and

(B) the children's health insurance program under ~~IC 16-35-6.~~ **IC 12-17.6.**

(2) Information on how to assist pregnant women, parents, guardians, and other individuals in completing and filing the application forms.

SECTION 17. IC 12-15-2.2-11 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 11. The office ~~shall~~ **may** adopt rules under IC 4-22-2 to implement this chapter, including rules that may impose additional requirements for qualified entities that are consistent with federal regulations.

SECTION 18. IC 12-15-4-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5. The office shall implement outreach strategies that build on community resources.**

SECTION 19. IC 12-15-12-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 13. For a managed care program established or authorized by the office, or established or authorized by another entity or agency working in conjunction with or under agreement with the office, the office shall:**

(1) administer the managed care program on a community level to the greatest extent possible; and

(2) offer to contract with, and encourage contracts from, community entities, including private entities, to manage any of the following:

(A) Outreach for and enrollment in the managed care program.

(B) Provision of services.

(C) Consumer education and public health education.

(D) Day to day administration of the managed care program.

SECTION 20. IC 12-15-20-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. The Medicaid

Copy

indigent care trust fund is established to pay the state's share of the following:

(1) Enhanced disproportionate share payments to providers under IC 12-15-19.

(2) Disproportionate share payments and significant disproportionate share payments for certain outpatient services under IC 12-15-17-3.

(3) Medicaid payments for pregnant women described in IC 12-15-2-13 and infants and children described in IC 12-15-2-14. ~~IC 12-15-2-15, and IC 12-15-2-15.5.~~

(4) Municipal disproportionate share payments to providers under IC 12-15-19-8.

SECTION 21. IC 12-15-33-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. The Medicaid advisory committee is created to act in an advisory capacity to the **following:**

(1) The office in the administration of the Medicaid program.

(2) The children's health policy board established by IC 4-23-27-2 in directing policy coordination of children's health programs.

SECTION 22. IC 12-17.6 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

ARTICLE 17.6. CHILDREN'S HEALTH INSURANCE PROGRAM

Chapter 1. Definitions

Sec. 1. The definitions in this chapter apply throughout this article.

Sec. 2. "Crowd out" means the:

(1) number of families who drop employer-offered health insurance coverage compared to the number of all families in the program; and

(2) percent of employers that have dropped the offer of family health insurance coverage since the program's inception.

Sec. 3. "Fund" refers to the children's health insurance program fund established by IC 12-17.6-7-1.

Sec. 4. "Insurer" means any person who provides health insurance in Indiana. The term includes the following:

(1) A licensed insurance company.

(2) A health maintenance organization.

(3) A multiple employer welfare arrangement.

(4) A person providing a plan of health insurance subject to

Copy

state insurance law.

Sec. 5. "Office" refers to the office of the children's health insurance program established by IC 12-17.6-2-1.

Sec. 6. "Physicians' services" has the meaning set forth in 42 U.S.C. 1395x(q).

Sec. 7. "Program" refers to the children's health insurance program established by IC 12-17.6-2.

Sec. 8. (a) "Provider" means an individual, a partnership, a corporation, a governmental entity, or an insurer that is enrolled in the Medicaid program under rules adopted under IC 4-22-2 by the office of Medicaid policy and planning.

(b) For purposes of IC 12-17.6-5-5(b), the term includes a limited service health maintenance organization (as defined in IC 27-13-34-4) and a preferred provider plan (as defined in IC 27-8-11-1).

Chapter 2. Program Administration

Sec. 1. The office of the children's health insurance program is established within the office of the secretary.

Sec. 2. The office shall design and administer a system to provide health benefits coverage for children eligible for the program.

Sec. 3. To the greatest extent possible, the office shall use the same eligibility determination, enrollment, and claims payment systems as are used by the Medicaid managed care program for children.

Sec. 4. The office shall evaluate the feasibility of the following:

(1) Establishing a program of employer based subsidies to encourage employers to provide coverage under the program.

(2) Expanding health insurance coverage under the program to other populations as provided under section 2105(c)(3) of the federal Social Security Act.

Sec. 5. The office shall do the following:

(1) Establish performance criteria and evaluation measures.

(2) Monitor program performance.

(3) Assess monetary penalties against a managed care organization or provider that fails to comply with the requirements of this article or a rule adopted under this article.

(4) Adopt a sliding scale formula that:

(A) specifies the premiums, if any, to be paid by the parent or guardian of a child enrolled in the program; and

(B) is based on the child's family income.

Copy

Sec. 6. (a) The office shall adopt rules under IC 4-22-2 to implement the program.

(b) The office may adopt emergency rules under IC 4-22-2-37.1 to implement the program on an emergency basis.

Sec. 7. (a) The office shall offer to contract with, and shall encourage contracts from, community entities, including private entities, to manage any of the following:

(1) Outreach for and enrollment in the program.

(2) Provision of health care services.

(3) Consumer education and public health education.

(4) Day to day administration of the program.

(b) The office shall administer the program on a community level to the greatest extent possible.

Sec. 8. Not later than April 1 of each year, the office shall provide a report describing the program's activities during the preceding calendar year to the:

(1) state budget committee;

(2) legislative council; and

(3) children's health policy board established by IC 4-23-27-2.

Chapter 3. Eligibility, Outreach, and Enrollment

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. (a) In order to be eligible to enroll in the program, a child must meet the following requirements:

(1) The child is less than nineteen (19) years of age.

(2) The child is a member of a family with an annual income of:

(A) more than one hundred fifty percent (150%); and

(B) not more than two hundred percent (200%);

of the federal income poverty level.

(3) The child is a resident of Indiana.

(4) The child meets all eligibility requirements under Title XXI of the federal Social Security Act.

(5) The child's family agrees to pay any cost sharing amounts required by the office.

(6) Except as provided in subsection (b), the child must be uninsured for at least three (3) months.

(b) The following are exempted from the requirement under subsection (a)(6):

(1) A child who is a member of the high risk pool and who has ongoing medical needs.

(2) A child who loses coverage through the termination of a parent's employer plan.

Copy

(3) A child whose parents have lost jobs with insurance coverage.

(4) A child who loses insurance coverage due to the divorce of the child's parents.

(c) The office may adjust eligibility requirements based on available program resources under rules adopted under IC 4-22-2.

Sec. 3. (a) Subject to subsection (b), a child who is eligible for the program shall receive services from the program until the earlier of the following:

(1) The end of a period of twelve (12) consecutive months following the determination of the child's eligibility for the program.

(2) The child becomes nineteen (19) years of age.

(b) Subsection (a) applies only if the child and the child's family comply with all enrollment requirements.

Sec. 4. The office shall implement outreach strategies that build on community resources.

Sec. 5. A child may apply at:

(1) an enrollment center as provided in IC 12-15-4-1; or

(2) the office of a qualified entity under IC 12-15-2.2;

to receive health care services from the program if the child meets the eligibility requirements of section 2 of this chapter.

Sec. 6. (a) The office shall enter into contracts under IC 5-22 with the following:

(1) An advertising or public relations agency or partnership for professional design and communication plans for the program.

(2) A professional market research organization to improve outreach and enrollment.

(b) The office shall provide the program with a memorable name and identity.

Sec. 7. (a) The office shall incorporate creative methods, reflective of community level objectives and input, to do the following:

(1) Encourage beneficial and appropriate use of health care services.

(2) Pursue efforts to enhance provider availability.

(b) In determining the best approach for each area, the office shall, in collaboration with communities, do the following:

(1) Evaluate distinct market areas.

(2) Weigh the advantages and disadvantages of alternative delivery models including the following:

Copy

(A) Risk-based managed care only.

(B) Primary care gatekeeper model only.

(C) A combination of clauses (A) and (B).

Chapter 4. Benefits, Crowd Out, and Cost Sharing

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. (a) The benefit package provided under the program shall focus on age appropriate preventive, primary, and acute care services.

(b) The office shall offer health insurance coverage for the following basic services:

(1) Inpatient and outpatient hospital services.

(2) Physicians' services provided by a physician (as defined in 42 U.S.C. 1395x(r)).

(3) Laboratory and x-ray services.

(4) Well-baby and well-child care, including:

(A) age appropriate immunizations; and

(B) services provided under the early and periodic screening, diagnosis, and treatment program (EPSDT) under IC 12-15.

The office may offer services in addition to those listed in this subsection as long as appropriations to the program exist to pay for the additional services.

(c) The office shall offer health insurance coverage for the following additional services if the coverage for the services has an actuarial value equal to the actuarial value of the services provided by the benchmark program determined by the children's health policy board established by IC 4-23-27-2 for the following:

(1) Prescription drugs.

(2) Mental health services.

(3) Vision services.

(4) Hearing services.

(5) Dental services.

(d) Notwithstanding subsections (b) and (c), the office may not impose treatment limitations or financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses.

(e) The children's health policy board established by IC 4-23-27-2 shall annually:

(1) review the benefits provided to program enrollees; and

(2) adjust the benefits as needed to remain within the program's appropriations.

Copy

Sec. 3. Premium and cost sharing amounts established by the office are limited to the following:

(1) Deductibles, coinsurance, or other cost sharing are not permitted with respect to benefits for well-baby and well-child care, including age appropriate immunizations.

(2) Premiums, deductibles, and other cost sharing may be imposed on a sliding scale related to family income. However, the total annual aggregate cost sharing with respect to all children in a family under this article may not exceed five percent (5%) of the family's income for the year.

Sec. 4. The office shall adopt rules under IC 4-22-2 to do the following:

(1) Determine cost sharing amounts.

(2) Adopt additional methods for complying with federal requirements relating to crowd out.

Sec. 5. (a) It is a violation of IC 27-4-1-4 if an insurer, or an insurance agent or insurance broker compensated by the insurer, knowingly or intentionally refers an insured or the dependent of an insured to the program for health insurance coverage when the insured already receives health insurance coverage through an employer's health care plan that is underwritten by the insurer.

(b) The office shall coordinate with the children's health policy board under IC 4-23-27 to evaluate the need for standards that minimize the incentive for an employer to eliminate or reduce health care coverage for an employee's dependents.

Chapter 5. Provider Agreements

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. A provider agreement must do the following:

(1) Include information that the office finds necessary to facilitate carrying out IC 12-17.6.

(2) Prohibit the provider from requiring payment from an enrollee of the program, except where a copayment is required by law.

Sec. 3. A provider who participates in the program must comply with the enrollment requirements that are established under IC 12-15.

Sec. 4. (a) A provider that participates in the Medicaid program as provided in IC 12-15-11 is considered a provider for purposes of the program.

(b) A provider that enters into a provider agreement with the program under this chapter is considered to be a provider in the Medicaid program under IC 12-15.

C o p y

Sec. 5. (a) The office may contract with providers that are insurers under IC 5-22 to arrange to provide health insurance or health services to a child who is enrolled in the program. A contract established under this subsection must require an insurer to do the following:

(1) Serve as a qualified entity (as defined in IC 12-15-2.2-1) in order to determine the presumptive eligibility for pregnant women and children for Medicaid as provided in IC 12-15-2.2.

(2) Assist a presumptively eligible individual under subdivision (1) to select a primary care provider.

(3) Establish locations where an applicant may apply to receive services provided by the program.

(4) Provide education concerning the following:

(A) The responsible use of health facilities and information.

(B) Preventive care.

(C) Parental responsibilities for a child's health care.

(5) Provide outreach and evaluation activities for the program.

(b) The office may contract with providers that are insurers to arrange to provide the services described in IC 12-17.6-4-2. An insurer under this subsection must:

(1) be eligible to receive reimbursement from the office; and

(2) comply with subsection (a)(3), (a)(4), and (a)(5).

Chapter 6. Provider Sanctions, Theft, Kickbacks, and Bribes

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. If after investigation the office finds that a provider has violated this article or rule adopted under this article, the office may impose at least one (1) of the following sanctions:

(1) Deny payment to the provider for program services provided during a specified time.

(2) Reject a prospective provider's application for participation in the program.

(3) Terminate a provider agreement allowing a provider's participation in the program.

(4) Assess a civil penalty against the provider in an amount not to exceed three (3) times the amount paid to the provider in excess of the amount that was legally due.

(5) Assess an interest charge, at a rate not to exceed the rate established by IC 24-4.6-1-101(2) for judgments on money, on the amount paid to the provider in excess of the amount that was legally due. The interest charge accrues from the date of

Copy

the overpayment to the provider.

Sec. 3. In addition to any sanction imposed on a provider under section 2 of this chapter, a provider convicted of an offense under IC 35-43-5-7.2 is ineligible to participate in the program for ten (10) years after the conviction.

Sec. 4. A provider may appeal a sanction imposed under section 2 of this chapter under rules concerning appeal that are adopted by the office under IC 4-22-2.

Sec. 5. After exhausting all administrative remedies, a provider may obtain judicial review of a sanction under IC 4-21.5-5.

Sec. 6. A final directive made by the office that:

(1) denies payment to a provider for medical services provided during a specified period of time; or

(2) terminates a provider agreement permitting a provider's participation in the program;

must direct the provider to inform each eligible recipient of services, before services are provided, that the office will not pay for those services if provided.

Sec. 7. Subject to section 8 of this chapter, a final directive:

(1) denying payment to a provider;

(2) rejecting a prospective provider's application for participation in the program; or

(3) terminating a provider agreement allowing a provider's participation in the program;

must be for a sufficient time, in the opinion of the office, to allow for the correction of all deficiencies or to prevent further abuses.

Sec. 8. Except as provided in section 10 of this chapter, a provider sanctioned under section 2 of this chapter may not be declared reinstated as a provider under this article until the office has received the following:

(1) Full repayment of the amount paid to the provider in excess of the proper and legal amount due, including any interest charge assessed by the office.

(2) Full payment of a civil penalty assessed under section 2(4) of this chapter.

Sec. 9. Except as provided in section 10 of this chapter, a provider sanctioned under section 2 of this chapter may file an agreement as provided in IC 12-17.6-5.

Sec. 10. A provider who has been:

(1) convicted of a crime relating to the provision of services under this chapter; or

(2) subjected to a sanction under section 2 of this chapter on

Copy

three (3) separate occasions by directive of the office;

is ineligible to submit claims for the program.

Sec. 11. Evidence that a person or provider received money or other benefits as a result of a violation of a:

(1) provision of this article; or

(2) rule established by the office under this article;

constitutes prima facie evidence, for purposes of IC 35-43-4-2, that the person or provider intended to deprive the state of a part of the value of the money or benefits.

Sec. 12. A person who furnishes items or services to an individual for which payment is or may be made under this chapter, and who knowingly or intentionally solicits, offers, or receives a:

(1) kickback or bribe in connection with the furnishing of the items or services or the making or receipt of the payment; or

(2) rebate of a fee or charge for referring the individual to another person for the furnishing of items or services;

commits a Class A misdemeanor.

Chapter 7. Funding

Sec. 1. The children's health insurance program fund is established. The fund is a revolving fund for the purpose of paying all expenses relating to:

(1) the program; and

(2) children who are eligible for:

(A) Medicaid under IC 12-15-2-14; and

(B) reimbursement under Title XXI of the federal Social Security Act.

Sec. 2. The office shall administer the fund.

Sec. 3. The fund consists of the following:

(1) Amounts appropriated by the general assembly.

(2) Amounts appropriated by the federal government.

(3) Fees, charges, gifts, grants, donations, money received from any other source, and other income funds as may become available.

Sec. 4. The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested.

Sec. 5. Money in the fund at the end of a state fiscal year does not revert to the state general fund.

Chapter 8. Appeals and Hearings

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. An applicant for or a recipient of services under the

Copy

program may appeal to the office under at least one (1) of the following conditions:

(1) An application or a request is not acted upon by the office within a reasonable time after the application or request is filed.

(2) The application is denied.

(3) The applicant or recipient is dissatisfied with the action of the office.

Sec. 3. The secretary shall conduct hearings and appeals concerning the program under IC 4-21.5.

Sec. 4. The office shall, upon receipt of notice of appeal under section 2 of this chapter, set the matter for hearing and give the applicant or recipient an opportunity for a fair hearing in the county in which the applicant or recipient resides.

Sec. 5. (a) At a hearing held under section 4 of this chapter, the applicant or recipient and the office may introduce additional evidence.

(b) A hearing held under section 4 of this chapter must be conducted under rules adopted by the office that are not inconsistent with IC 4-21.5 and the program.

Sec. 6. The office:

(1) may make necessary additional investigations; and

(2) shall make decisions concerning the:

(A) granting of program services; and

(B) amount of program services to be granted;

to an applicant or a recipient that the office believes are justified and in conformity with the program.

Chapter 9. Confidentiality and Release of Information

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. The following concerning a program applicant or recipient under the program are confidential, except as otherwise provided in this chapter:

(1) An application.

(2) An investigation report.

(3) An information.

(4) A record.

Sec. 3. The use and the disclosure of the information described in this chapter to persons authorized by law in connection with the official duties relating to:

(1) financial audits;

(2) legislative investigations; or

(3) other purposes directly connected with the administration

Copy

of the program;

is authorized.

Sec. 4. (a) The release and use of information of a general nature shall be provided as needed for adequate interpretation or development of the program.

(b) The information described in subsection (a) includes the following:

(1) Total program expenditures.

(2) The number of recipients.

(3) Statistical and social data used in connection with studies.

(4) Reports or surveys on health and welfare problems.

Sec. 5. The office shall make available the following to providers for immediate access to information indicating whether an individual is eligible for the program:

(1) A twenty-four (24) hour telephone system.

(2) A computerized data retrieval system.

Sec. 6. Information released under section 5 of this chapter is limited to the following:

(1) Disclosure of whether an individual:

(A) is eligible for the program; or

(B) has an application pending.

(2) The date the individual became eligible for the program and the individual's program number.

(3) Restrictions, if any, on the scope of services to be reimbursed under the program for the individual.

(4) Information concerning third party liability.

Sec. 7. Information obtained by a provider under this chapter concerning an individual's eligibility for the program is confidential and may not be disclosed to any person.

Sec. 8. If it is established that a provision of this chapter causes the program to be ineligible for federal financial participation, the provision is limited or restricted to the extent that is essential to make the program eligible for federal financial participation.

SECTION 23. IC 35-43-5-7.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 7.2. (a) Except as provided in subsection (b), a person who knowingly or intentionally:**

(1) files a children's health insurance program claim, including an electronic claim, in violation of IC 12-17.6;

(2) obtains payment from the children's health insurance program under IC 12-17.6 by means of a false or misleading oral or written statement or other fraudulent means;

Copy

(3) acquires a provider number under the children's health insurance program except as authorized by law;

(4) alters with intent to defraud or falsifies documents or records of a provider (as defined in 42 CFR 1002.301) that are required to be kept under the children's health insurance program; or

(5) conceals information for the purpose of applying for or receiving unauthorized payments from the children's health insurance program;

commits insurance fraud, a Class D felony.

(b) The offense described in subsection (a) is a Class C felony if the fair market value of the claim or payment is at least fifty thousand dollars ($50,000).

SECTION 24. THE FOLLOWING ARE REPEALED [EFFECTIVE UPON PASSAGE]: IC 12-15-2.2-12; IC 12-17-18.

SECTION 25. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 1999]: IC 12-15-2-15; IC 12-15-2-15.5.

SECTION 26. [EFFECTIVE UPON PASSAGE] **(a) Notwithstanding IC 12-17.6, as added by this act, the children's health insurance program shall begin operations not later than January 1, 2000.**

(b) This SECTION expires January 1, 2001.

SECTION 27. [EFFECTIVE UPON PASSAGE] **(a) Notwithstanding IC 4-23-27-10, as added by this act, the first evaluation of the children's health insurance program under IC 12-17.6 must be completed before July 1, 2001.**

(b) This SECTION expires July 1, 2002.

SECTION 28. **An emergency is declared for this act.**

Copy